Nutrition History and Questionnaire

Florida Surgical Weight Loss Center

First Name: ____
Last Name: ____
DOB: ____
Occupation: ____
Highest Education Level Completed:

- ☐ Grade School
- ☐ High School
- ☐ College
- ☐ Graduate Degree

Surgery Type:

- ☐ AP Laparoscopic Band Placement
- ☐ Gastric Sleeve

Surgeon: ____
Anticipated date of surgery (if known): ____

Medical History (please check all that apply)

- ☐ Arthritis
- ☐ Cancer Type:_____________
- ☐ Depression
- ☐ Eating Disorder
- ☐ Gastric Reflux
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ High Triglyceride Level
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Orthopedic surgery
- ☐ Orthopedic surgery
- ☐ Shortness of Breath upon Exertion
- ☐ Sleep Apnea
- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes

Please list any food allergies or intolerances: ____
____

Why do you want to lose weight?

____
____
____

What are some of the things that have kept you from accomplishing weight loss?

____
____
____

Who would you consider your "support persons" during this process?

____

____

Height: ____

Weight:____

What is your goal weight?____

What is the most you have weighed (in your adult life) and at what age? _________________________

What is the lowest you have weighed (in your adult life) and at what age? ________________________

Past Attempts at Weight Loss (please be as specific as possible):

- ☐ **Weight Watchers**
  Duration: ________________________
  Amount of Weight Lost: _________lbs
  Reason for Stopping Program:
  ____
- ☐ **Jenny Craig**
  Duration: ________________________
  Amount of Weight Lost: _________lbs
  Reason for Stopping Program:
  ____
- ☐ **Nutrisystem**
  Duration: ________________________
  Amount of Weight Lost: _________lbs
  Reason for Stopping Program:
  ____
- ☐ **Optifast**
  Duration: ________________________
  Amount of Weight Lost: _________lbs
  Reason for Stopping Program:
  ____
- ☐ **SlimFast**
  Duration: ________________________
  Amount of Weight Lost: _________lbs
  Reason for Stopping Program:
  ____
- ☐ **Atkins**
  Duration: ________________________
  Amount of Weight Lost: _________lbs
  Reason for Stopping Program:
  ____
- ☐ **Zone Diet**
  Duration: ________________________
  Amount of Weight Lost: _________lbs
  Reason for Stopping Program:
  ____
- ☐ **HCG Diet**
  Duration: ________________________
  Amount of Weight Lost: _________lbs
  Reason for Stopping Program:
  ____
- ☐ **South Beach Diet**
  Duration: ________________________
  Amount of Weight Lost: _________lbs
  Reason for Stopping Program:
  ____
- ☐ **Overeaters Anonymous**
  Duration: ________________________
  Amount of Weight Lost: _________lbs
  Reason for Stopping Program:
  ____
- ☐ **Paleo Diet**
  Duration: ________________________
  Amount of Weight Lost: _________lbs
  Reason for Stopping Program:
  ____
- ☐ **Hypnosis**
  Duration: ________________________
  Amount of Weight Lost: _________lbs
  Reason for Stopping Program:
  ____

☐ **MediWeight Loss**
Duration: _________________________
Amount of Weight Lost: _________lbs
Reason for Stopping Program:
____

☐ **Physician-supervised Diet**
Duration: _________________________
Amount of Weight Lost: _________lbs
Reason for Stopping Program:
____

☐ **Dietitian-prescribed Diet**
Duration: _________________________
Amount of Weight Lost: _________lbs
Reason for Stopping Program:
____

☐ **Cleanse/Detox Diet**
Duration: _________________________
Amount of Weight Lost: _________lbs
Reason for Stopping Program:
____

☐ **Any other "fad" diet**
Elaborate: _________________________
Duration: _________________________
Amount of Weight Lost: _________lbs
Reason for Stopping Program:
____

☐ **Self Diet**
Elaborate: _________________________
Duration: _________________________
Amount of Weight Lost: _________lbs
Reason for Stopping Program
____

Have you ever taken prescription or over-the-counter medications for weight loss, suppression of appetite or other dieting reason? If yes, please indicate below:

Type: __________
Duration: _________________________
Amount of Weight Lost: _________lbs
Reason for Stopping________________

Type: __________
Duration: _________________________
Amount of Weight Lost: _________lbs
Reason for Stopping________________

Have you ever attended a weight-loss retreat, rehab, or spa? If so, please indicate below:

Type: __________
Duration: _________________________
Amount of Weight Lost: _________lbs
Reason for Stopping________________

Type: __________
Duration: _________________________
Amount of Weight Lost: _________lbs
Reason for Stopping_______________

Please provide details of any previous surgeries or other weight-loss measures you have undergone that were not previously mentioned:
____
____
____

Please list all vitamins, herbs or other dietary supplements you take and how often:
____
____
____

How many times per week do you typically consume "fast food"? __________times per week
How many times per week do you eat out at dine-in restaurants? __________times per week
Please list the names/types of the restaurants at which you tend to eat (ex: McDonald's, BBQ, Chinese takeout, etc.):

____
____
____

How many meals per day are prepared and consumed at home? __________ meals per day

How many times per day do you consume "sweets"? __________ per day
Please list the types of sweets you consume and how often: (ex: cookies, ice cream, chocolate, donuts, etc):

____

How many times *per day* do you consume…

Soda?	Never	1-2	3-5	>5
Diet Soda?	Never	1-2	3-5	>5
100% Fruit Juice?	Never	1-2	3-5	>5
Tea?	Never	1-2	3-5	>5
Sweet Tea?	Never	1-2	3-5	>5
Fruit-flavored drinks?	Never	1-3	3-5	>5
Coffee?	Never	1-3	3-5	>5

What do you usually add to your coffee? ____

Water?	Never	1-3	3-5	>5

Please check the condiments that you usually consume *at least 3-5 times per week or more*:

- ☐ Butter
- ☐ Mayonnaise
- ☐ Olive Oil
- ☐ Margarine
- ☐ Oil-based Salad Dressing
- ☐ Cream-based Salad Dressing
- ☐ Canola Oil
- ☐ Mustard
- ☐ BBQ Sauce
- ☐ Tabasco Sauce
- ☐ Whipped Cream
- ☐ Syrup
- ☐ Honey
- ☐ Agave Nectar
- ☐ Other; please specify:___________

How many times *per day* do you consume vegetables?

- ☐ I do not consume vegetables
- ☐ 1-2 times per day
- ☐ 3-5 times per day
- ☐ >5 times per day

What are your favorite types of vegetables to consume? ______________________________________

How many times *per day* do you consume fruits?

- ☐ I do not consume fruits
- ☐ 1-2 times per day
- ☐ 3-5 times per day
- ☐ >5 times per day

What are your favorite types of fruits to consume? ____

How many times per day do you consume meat?

- ☐ I do not consume meat
- ☐ 1-2 times per day
- ☐ 3-5 times per day
- ☐ >5 times per day

What are your favorite types of meats to consume? ____

If you are a vegetarian or vegan, what are your sources of protein in your diet?

____

Do you consume alcohol? Yes No

If yes, how often?

- ☐ Never
- ☐ 1-2 times per week
- ☐ 3-5 times per week
- ☐ Daily

What type of alcoholic drinks do you usually consume?

- ☐ Beer
- ☐ Wine
- ☐ Liquor
- ☐ Mixed Drinks

Do you smoke? Yes No

If yes : ________pack(s) per day

Please indicate which dieting barriers apply to you most:

- ☐ Portion sizes
- ☐ Not feeling full
- ☐ Snacking
- ☐ Late night hunger
- ☐ Binge eating
- ☐ Emotional eating
- ☐ Stress eating
- ☐ Lack of knowledge regarding "healthy foods" or diets
- ☐ Financial barriers
- ☐ Temptations within household
- ☐ Work schedule
- ☐ Other; please specify:____________ __________________

Do you exercise? Yes No

If yes, please list the types of physical activity below:

Physical Activity	How Many Times Per Week	How Many Minutes

If no, please describe any physical disabilities or other reasons that would prevent you from participating in a fitness routine:

____

____